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ABSTRACT

This practicum report describes a project to improve safety and health conditions for state-licensed family child care homes. Since the family child care providers in the study area do not have to meet more than minimum state health and safety requirements, providers have limited knowledge of and need to improve health and safety standards in their family child care homes. Telephone surveys and interviews with state officials and providers documented the need for health and safety training, but no group had attempted to meet the need. A literature survey revealed that training would help strengthen the quality of family child care homes and improve the professionalism of providers. Six training workshops were offered to 20 providers on methods to improve health and safety and to deal with emergency/crisis situations. Workshops were supplemented with in-home technical assistance on health and safety. Topics covered were orientation, self-esteem, safety, creating healthy environments, professionalism, and rescue organization. A statewide rescue registration program was also organized. The projected outcomes of the practicum goal were: 15 of the 20 family child care providers would register their homes with local fire/rescue departments; 15 of the 20 family providers would improve the health and safety in their homes (as measured by a checklist); and 5 of the 20 providers would join a statewide rescue committee. At the conclusion, 14 providers had registered, 20 had satisfied the checklist, and 2 had joined the rescue committee. Three appendixes containing the rescue registration form and checklists are included. Contains 32 references. (TM)

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Improving the Safety Standards of Family Child Care Homes by Developing and Implementing a Health and Safety Training Program for State-Licensed Family Child Care Providers

by

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CHAPTER I

INTRODUCTION

Description of Community

The writer's community in a small New England state is a small upper-middle class suburban town of 20,000 that is just two miles outside the state's capital city. The town has all the features and amenities that make it an ideal place for families to reside. Within the writer's community are 5 family child care homes, and within the writer's state there are approximately 600 licensed family child care homes, with another 200 family child care homes pending a license. Family child care homes are licensed by the state's child care licensing agency.

Eighty percent of the state-licensed family child care providers own their own homes, and 20% rent their homes. Ninety-five percent of the family child care providers are from the middle-income group, and the remaining 5% are from the lower-income group. Approximately 33% of the state-licensed home providers are members of the state family child care association, and only about 5% of the members are active members.

Individual family child care providers do not have to apply for certification if they care for one or two children; however, certification is required by state law when a family child care provider is caring for four to

eight children. Most family child care homes are located in areas zoned residential. The providers are predominately white middle-class females who independently provide care out of their own homes for up to six children or employ a full-time assistant and provide care for eight children. The children range in age from infancy to school age. The provider's own children are usually a part of the family child care home setting.

Writer's Work Setting and Role

The writer and her husband are the co-proprietors of a state-licensed family child care home, which they operate out of their own home; the home provides quality care for eight children. The writer has operated the home-based family child care for over 21 years, and for the first 17 years the writer was involved just in the home-based family child care. However, during the last five years, the writer became the co-owner and executive director of three child care centers, and the writer took on additional duties as a part-time child care consultant for the day care profession and for a leading supply catalog company.

The writer's home family child care is located directly across the street from one of the town's four elementary schools, making it convenient for parents seeking care for their school-age children. The family child care home itself is based in an apartment over a two-car garage, which is connected to the writer's home.

The writer's family child care meets all the state building and fire code requirements that apply to family child care homes. The 28-foot-by-28-foot family child care home has indoor areas for play and rest, and it features child-sized equipment. Additionally, the family child care is separated into areas for housekeeping, dress-up, blocks, library, and writing. There is an adjacent backyard play area that is also furnished with child-sized equipment, including a sandbox, a swing set, a slide, and a playing field.

The writer's business employs two part-time state-licensed assistants as well as the writer's husband, who works full time in the family child care and is state-licensed. The writer serves as a substitute when an employee is absent, and additionally provides staff training, while developing and overseeing the program and the curriculum.

The writer is an active member and past-president of the state family child care association, is the co-chairperson of the family child care legislation committee of the state family child care association, and represents the association on a state child care commission. The writer was the leader in lobbying for and obtaining statewide family child care zoning that allows family child care homes to operate in residential areas, and she was the co-chairperson responsible for creating a new category of family child care called "group family child care," which is the designation given for the care of 9 to 12 children.

The writer is actively involved in many statewide committees related

to the child care profession, she is currently a member of her town school committee, and she is actively involved in town wide committees that relate to children, youth, and families.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

In the writer's state, state-licensed family child care providers did not have to meet more than minimum state health and safety requirements. Consequently, providers had limited knowledge of how to provide healthy and safe family child care homes, and therefore, they needed to improve health and safety standards in their family child care homes.

While the state had an obvious concern for the safety and welfare of children attending family child care homes, it had been unable to enact more stringent safety and health regulations because of a reduction in the number of state employees and a lack of any state funding earmarked for such an effort. In fact, state funding for children and youth had actually decreased each year over the past several years, and there had been limited state money available for special programs. As a result, the state child care agency had chosen not to update the agency's regulations that govern day care certification.

While some state-licensed family child care providers may have felt improving health and safety regulations on their own initiative was a good idea, the providers, because of their own budgetary constraints, had lacked

the money to invest in the process. Additionally, since there had been few advocates for enhanced health and safety standards, family child care providers had not moved toward achieving higher standards in their family child care homes. As a result, the providers had not needed to nor had they moved to achieve higher levels of health and safety in their own homes, levels that exceed state licensing requirements. Those most affected by the lack of enhanced health and safety regulations in family child care homes were the children enrolled in the family child cares and the families of those children.

Problem Documentation

According to telephone surveys conducted by the writer, six providers indicated that they had received, through a recent national accreditation project, training for enhancing health and safety standards in their family child care homes. Other less formal training in various forms had been offered throughout the state from time to time; however, no technical in-home advanced training had ever been conducted. In their phone conversations with the writer, representatives from state and federal government agencies directly concerned with children and youth all stated that family child care providers should receive advanced health and safety training. These agencies included the state child care training system, the state child care licensing agency, the state agency handling state tuition

reimbursement for income-eligible families, the state family child care association, and the agency that administers the federal food program.

Additional telephone conversations with the state family child care association revealed that the agency also felt that family child care homes were in need of healthy and safe child care environments that exceeded those demanded by state regulations. As previously mentioned, other than the small pilot program in which a few providers received formal training in the areas of health, safety, CPR, and first aid, there had not been any priority given to training providers in these areas.

In phone conversations with the writer, many family child care providers stated they too felt that they needed additional training in health and safety. This was confirmed once again at a monthly meeting of the state's family child care association where the writer spoke to the association's membership about the need for additional training in health and safety. After the talk, many family child care providers approached the writer and expressed interest in receiving health and safety training. Additionally, the state's licensing agency told the writer that as a result of the recent training (mentioned above) a few providers had been given, other family child care providers were calling to find out if more training would be offered.

In an informal meeting with the state child care licensing agency and phone conversations with the state fire marshal's office, the writer was told

that few if any family child care homes were registered with their local rescue/fire departments. The fire marshal's office and the state child care licensing agency felt that a family child care registration process would add a measure of safety to the family child care homes. Both offices affirmed that the writer's state did not have in place (nor did they have plans for) a statewide rescue registration process for family child care homes.

Causative Analyses

There were several reasons why there was no advanced training in the areas of health and safety. Among the leading causes were the following:

1. Many family child care providers felt that state licensing regulations for health and safety were already sufficient.
2. There was not adequate awareness regarding the topic of health and safety in a family child care home.
3. The state did not have the resources to publicize the need for added health and safety measures in the family child care providers' homes.
3. Providers were isolated in their homes.
4. It was difficult for family child care providers to get involved in training since they were self-employed and worked 50 to 60 hours per week.

5. The state family child care association had not made health and safety improvements to family child care homes a top priority.
6. State and federal agencies had limited funds for training and/or the implementation of additional projects, such as health and safety training for family child care providers.
7. Many providers did not have formal education in either early childhood development or a related field; this may have caused them to lack the self-esteem that would normally encourage them to seek additional training and assist them through the training process.
8. The providers generally were reluctant to invite more state or national officials into their homes for fear of being required to perform extensive and/or expensive changes to their family child care home.
9. From interviews, observations, and personal experience, the writer was well aware that as a rule, providers' budgets were tight and limited to covering the essentials, such as wages and supplies; consequently, if there was a charge associated with training, providers may not have felt they had enough money to pay for additional training.

While it was within the scope of the state child care association to allocate funds for additional training for providers, the subjects of health and

safety had never been a top priority. Also, the state family child care licensing agency had never appropriated money to pursue the implementation of higher standards in health and safety for family child care homes.

Interviews conducted by the writer with interested parties indicated nearly everyone was in agreement that there was a need for health and safety training for family child care providers; however, because of limited budgets, a lack of funding, and a shortage of staff, there had never been any health and safety training.

Without the presence of an outside force, most providers were not likely to undertake a search for training in health and safety. As mentioned above, providers typically worked 50 to 60 hours a week and were thus limited in the time they could spend investigating health and safety. When questioned by the writer, many providers initially indicated that the state certification process was sufficient to maintain adequate regulations, and many tended to be only somewhat aware how training in health and safety could be beneficial to them and their homes. However, upon closer questioning by the writer, the providers all indicated that they felt health and safety training would be highly beneficial to them.

While there was a demonstrable need for and interest in further training in the areas of health and safety, no individual or group had ever attempted to meet the need. The discussions the writer had with all the

concerned parties indicated that if there were to be a training project, it should be a formalized program that included a trainer, specific goals, and a time frame for completing the project.

Relationship of the Problem to the Literature

The literature review revealed that many researchers felt training was a major way to (a) strengthen the quality of a family child care home and (b) increase the professionalism of family child care providers.

Family-based child care is the most frequently used form of child care. In fact, it is chosen by nearly 90% of working families who use out-of-home arrangements for infants and a sizable proportion of those with preschoolers (Lurie, 1991), but regulatory guidelines for family child care in this country are a crazy quilt, varying strikingly from state to state (Rubenstein, 1993). Thacker, Addiss, Goodman, Holloway, and Spencer (1992) reported as the need for child day care services has risen, national attention has focused on the quality, availability, and costs associated with these services; however, issues of health and safety have not been addressed adequately.

Quality child care is essential for the physical, emotional, social, cognitive, and spiritual growth of children enrolled in a licensed provider's home. The more that providers work with children in the family child care home, the more those providers realize the importance of and need for increased knowledge in the areas of health and safety. Erheart and Leavitt

(1986) defined child care training as any course, workshop, conference, or college degree that is specifically concerned with child care. Modigliani (1991) suggested a need for qualified trainers and training programs.

The U.S. Senate Committee on Health and Human Resources (1984) held public hearings on the issue of child day care regulations. Much of the testimony that was heard pertained to the need for appropriate training for family day care. According to Gardner (1992), quality in a child care setting is increased with better regulations and increased availability in training.

LaFarge (1990) stated that family child care providers usually have less training in child development than child care center employees do. Lack of training, according to LaFarge, means that providers may not offer as rich an environment for learning as most parents would like. This reinforces conversations that the writer had with many family child care providers. Most of the family child care providers who spoke with the writer had not been formally educated in either the business aspects or the child development aspects of child care. The providers who spoke with the writer typically began their family child care because they wanted to (a) own their own business, (b) stay home with their own children, and (c) work with children. As a result, most of these providers, when interacting with children in a child care environment, relied only on their own upbringing as a model for interacting with children.

The writer found that there was generally a lack of self-esteem among

the child care providers with whom she spoke. Willer (1987) wrote that family child care providers reported that even the providers' own family members tended to consider the providers to be baby sitters and not valued professionals who were offering a much needed service.

Modigliani (1990) assessed the quality of family child care by examining how the provider prepared the environment in which children play and explore through hands-on activities. Modigliani found that when providers introduce a developmentally appropriate curriculum into the child care setting, the quality of learning increases for the children in the providers' care.

Erheart and Leavitt (1986) wrote that family child care training is generally looked upon as less important than the training given to employees of center-based care. The authors suggested that, at the very least, minimal training requirements should be incorporated into the process for home licensing and certification. Erheart and Leavitt also reported on (a) the on-going research into how different kinds of provider training influence the quality of child care in the home setting and (b) how or if providers' interest in training changes after the providers have received training.

Nelson (1989) reported that there was a significant improvement in the quality of child care offered by providers after the providers had participated in training. Cohen and Modigliani (1992) reported increased training improves the care that family child care providers offer.

Willer (1987) said that quality standards for home-based child cares differ from state to state and that the public's understanding of such regulations also vary from state to state. Nolan, Barr, Elarth, and Boase (1987) reported that 40% of children of working mothers receive child care in small, unlicensed private homes. Rassin, Beach, McCormick, Niebuhr, and Weller (1991) reported an estimated 80% of all children in child care are cared for by unlicensed care givers who are not required to comply with any health and safety standards. Erheart and Leavitt (1986) reported that only one of every three providers has had any training, yet training makes a demonstrable difference in the quality of care available in child care homes.

Even given their lack of training, family child care providers generally offer a safer and more healthful environment. Walker (1991) reported that licensed family providers are more likely than unlicensed providers to follow prescribed health and safety standards and offer sightly higher health and safety standards. Doyle (1976) reported that there was less reported incidence of illnesses in family child care as compared to centers, and the illnesses reported are low enough in frequency to indicate that children under the age of three can safely be cared for in groups.

Eichelberger, Gotshall, Feely, Harstad, and Bowman (1990) reported that injuries are the leading cause of death and disability for children after the first year of life, and according to Landman and Landman (1987) accidental death was the leading cause of death in childhood after the

neonatal period. Elardo, Solomons, and Snider (1986) reported that accidents are the leading cause of childhood mortality and rank second only to acute infections as the cause of morbidity and visits to the physicians throughout childhood. Elardo et al. (1986) also reported that most accidents occur in and around the home, even when supervision is good. Accidents are more frequent among children from families with chronic or acute health problems and emotional stress.

Davidson, Hughes, and O'Connor (1988) found that boys have many more injuries than girls, and that overactivity does not confer increased risk of injury; however, problems in discipline do constitute a risk factor. Snow (1991) reported that the largest number of injuries in family child care are in the birth to two-year-old group. The most hazardous days of the week are Tuesday and Thursday, while injuries are almost evenly divided among the morning and afternoon. Thacker, Addiss, Goodman, Holloway, and Spencer (1992) reported that injuries peak at about 11 a.m. and again at 4 p.m. and vary by season with the highest rates occurring in summer and spring. The playground was the most frequent site of injury. Chang, Lugg, and Nebedum (1989) reported that the majority of injuries in children occur between 9 a.m. and noon, and playground equipment is cited most often as the cause. This was reconfirmed by Aronson (1989) who reported that child care givers need to be particularly vigilant in mid-morning, late afternoon, and during the spring and fall. The majority of injuries in child

care programs occurred in gross motor play areas; climbers and slides account for the greatest number of injuries. Chang, Lugg, and Nebedum reported that the highest occurrence of children being injured was in October, while from November through March there was a lower occurrence of injury. Rivara, DiGuiseppi, Thompson, and Calonge (1989) reported injuries in child care settings occurred no more frequently and, given the number of hours spent in child care, perhaps less frequently, than injuries to children at home.

Gunn, Pinsky, Sacks, and Schonberger (1991) reported that although out-of-home child care may carry increased risk of infectious disease relative to home care, it did not appear to carry an increased risk of injury and, in fact, may confer a lower risk. However, Rennie (1993) stated that children at an unsafe child care facility for only four hours may be at a higher risk than those at a well-structured facility for eight hours.

McCormick, Brooks-Gunn, Shapiro, Benasich, Black, and Gross (1991) reported that group settings for young children constitute a well documented risk factor for infection, particularly respiratory tract and gastrointestinal infections. On the other hand, Hurwitz, Gunn, Pinsky and Schonberger (1991) stated that a small facility caring for two to six children has a reduced risk of respiratory illness when compared with a larger facility caring for more than six children.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The goal of the practicum was to have 20 family child care providers have safe and healthy family child care homes. The changes that were expected to be seen in the family child care homes were (a) the providers would increase their knowledge of health and safety as it related to their family child care homes, (b) the providers would make changes in their family child care homes that would reflect their increased knowledge of health and safety, and (c) the providers would register their family child care homes with their local fire/rescue department.

Expected Outcomes

The expected outcomes for provider training in health and safety were as follows:

1. Fifteen of 20 family child care providers in the writer's initial training group would register with their local fire/rescue departments as evidenced by the providers giving a copy of the completed form to the writer (see Appendix A).
2. Fifteen of 20 family child care providers would improve the quality of health and safety standards in their family child care home environments as indicated by their completing 30 of the

39 items on a checklist that the writer has developed (see Appendix B).

3. Five of 20 family child care providers would commit to becoming members of a committee to implement a statewide rescue registration project. The providers would sign a consent form stating they were willing to participate, and the writer would use a checklist to list all those who committed to become committee members.

Measurement of Outcomes

The first projected outcome was that 15 of 20 family child care providers would register with their local fire/rescue departments, and this would be measured by the providers submitting filled-in registration forms to both their local fire/rescue departments and the writer.

The second projected outcome was that 15 of 20 family child care providers would improve the quality of safety and health standards in their family child care homes as measured by the providers completing 30 out of 39 criteria on a checklist (see Appendix B) developed by the writer with input from the state family child care association and the state family child care licensing agency. The checklist listed health and safety areas in which the family child care provider needed improvement. Upon the provider's completion of the criteria, the writer would chart each provider's results.

The third projected outcome was that 5 of 20 family child care providers would sign a consent form agreeing to become members of a committee to implement the rescue registration project on a statewide basis. This was to be measured by the providers signing a form provided by the writer. After the providers signed the form, the writer was to check off that provider's name on the checklist.

CHAPTER IV

Solution Strategy

Discussion and Evaluation of Possible Solutions

The problem was that family child care providers in the writer's state had limited knowledge of and no training on how to provide a safe and healthy child care environment.

The literature cited several possible solutions. Levin (1991) suggested an emergency/crisis plan that would ensure that the participants would get a view of the entire scope of circumstances and emergencies that could occur in a child care. Levin's plan was designed for child care centers and suggested that centers (a) improve their effectiveness in responding to emergencies, (b) be prepared to ease any physical or emotional trauma that results from such emergencies, (c) take steps to limit legal and financial liability arising from any emergency situations, and (d) learn how to minimize negative publicity that may come about as a result of any emergencies.

Shuster, Stevenson, and Ward (1992) suggested a statewide training and technical assistance project for registered family child care providers, such as the one funded by the Connecticut Department of Human Services (CDHS). According to Shuster, et al., the CDHS offered more than 100

workshops annually in cooperation with local family child care associations.

A similar project was accomplished by the writer in 1993. The writer set up family child care national accreditation workshops in her state and offered weekly training sessions to several family child care providers. Among the accreditation areas covered by the writer were health and safety (Shallcross, 1993). Four family child care providers received national accreditation in the project.

In a telephone conversation with the State of Connecticut's family child care licensing agency (M. A. Shallcross, personal communication, July 1994), the writer learned that the Connecticut agency sent a quarterly newsletter to registered family child care providers, and the agency also provided a telephone number that family child care providers could call for assistance. These services were used by the State of Connecticut to assist the providers in their family child care business, and according to Connecticut's licensing agency, the family child care homes in the state were in better shape because of them.

In California, child care agencies made training programs available to established as well as new family child care providers (Lurie, 1991). Lurie suggested that offering family child care skills workshops to providers resulted in improved business skills, improved child development skills, and a lessened sense of isolation among the family child care providers.

Corsini (1991) reported that in Denmark the local communities

employed family child care system supervisors who were trained child care professionals with at least three years of study in young children. These supervisors were on call daily for providers' questions on standards.

Erheart and Leavitt (1986) suggested that in order to improve the quality of programs in family child cares, child care providers need training. Shuster, et al., maintained the necessity of offering technical assistance and workshops for family child care providers, and Lurie promoted training workshops to improve business and child development skills. Cohen and Modigliani (1992) suggested that (a) increased training improves the care that providers offer and (b) providers who participate in good training have improved their practice.

Description of Selected Solution

The writer chose to educate family child care providers (a) on methods that would improve the quality of health and safety in the providers' family child care homes and (b) on ways to deal with emergency/crisis situations (Levin, 1991). The writer chose to select 20 family child care providers and offer health and safety training as it related to family child care, training designed to help the providers go beyond the minimums set by state licensing requirements.

One of the important aspects of training that the writer learned from exploring the literature was the need to conduct the training workshops at a

convenient location and at times and dates that were also convenient to the participants (Erheart and Leavitt, 1986).

In her planning of the implementation, the writer was convinced that it would be appropriate to hold a preliminary workshop session to motivate and encourage providers' involvement in professional enrichment (Cohen and Modigliani, 1992). Family child care providers in the writer's state had written letters to the editor of the state child care association's newsletter expressing their feelings of insecurity about operating a small business all on their own. At family child care association meetings and conferences, family child care providers had consistently conveyed the desire for improvement in all areas of child care, especially the areas of health and safety.

To augment the workshop training seminars, the writer would provide in-home technical assistance in health and safety for the family child care providers (Shuster et al.). The writer would first come to know each provider through the workshops, and because the writer's professional credentials would be firmly established by the workshops, the participants would feel comfortable having the writer conduct the in-home technical visits and give the writer positive cooperation.

For the in-home technical visits, the writer would design and create a health and safety checklist that the family child care providers could use to assess health and safety conditions in their homes (Sibley and Abbott-Shim,

1992). In the recent past, many providers had requested that the state association send them more information about how they as providers could upgrade their homes. The checklists could act as a guideline for providers who were trying to upgrade the health and safety of their family child care homes.

The writer decided that it would also be appropriate to provide training to the state's child care licensing agency and the state fire marshal's office (Levin, 1991). The writer had contacted both the child care licensing agency and the fire marshal's office, and each expressed a desire for child care health and safety training to be made available to their staffs.

The writer planned to present at the annual family child care association conference (which would take place during the implementation period) a workshop on the topics of health and safety (Modigliani, 1991). The writer had been advised by the association's executive board that each year the association conference presented six workshops, and the association's board had chosen health and safety as the main topics for the 1995 conference.

Through print, the writer would promote an awareness of and the need for health and safety in family child care homes. The state family child care association newsletter had always welcomed articles on training, and in addition to presenting articles concerning the health and safety training to the newsletter, the writer planned to submit articles about the project to

local newspapers for possible publication.

Once the implementation began, the writer would give out her work telephone number to providers who were in training so the providers could call if they had any questions on the workshop training sessions (Corsini, 1991). In the past, providers had expressed a need for direct feedback from a knowledgeable person when the providers had a question concerning child care in their homes.

In order to help cover the implementation costs, such as printing, supplies, incidentals, etc., the writer would apply for funds through local and state grant sources as well as child care agencies and associations. Prior to the beginning of the implementation, the state family child care association offered to help fund the project, and a private human service agency offered to provide other needed resources.

Report on Action Taken

The implementation, as envisioned by the writer was divided into three elements.

1. The writer was to develop, implement, and evaluate a health and safety training program for 20 family child care providers. Included in the training would be six training sessions plus CPR/first aid training followed by individual on-site health and safety evaluations by the writer at the homes of the 20 child

care providers.

2. The writer was responsible for the design and development of a rescue registration form that family child care providers could send to their local fire/rescue departments. This form would let fire/rescue departments know that the provider's home was a family child care home. To help facilitate the process, the writer would set up a rescue registration committee. At the same time the writer was to work with and educate the state fire marshal's office and fire/rescue departments across the state about the rescue registration.

3. The writer would design and develop a health and safety checklist that (a) could be used by the writer during in-home technical visits to rate the 20 providers' homes on health and safety, and (b) be used by family child care providers statewide to rate their own homes.

During the first weeks of the implementation, the writer, working through the family state child care association, attempted to sign up 20 providers for health and safety training. However, only 5 providers expressed interest, leaving the writer well short of the 20 providers she had anticipated would enroll in the training program. In order to reach her goal of 20 providers, the writer approached the private human services agency to ask for their assistance. The agency oversaw a network of 24 family

child care providers that it hired as private contractors. In order to become a family child care provider for the private human service agency system, a provider had to first be a qualified state-licensed provider, and then the provider had to be interviewed and accepted by the agency. The agency was very conscious about quality standards in the family child care homes, and the director of the agency not only was very eager to have the agency's family child care providers receive training in health and safety, but also offered the agency's facilities as a site for the training sessions.

With the agency's assistance the writer signed up 20 of the agency's 24 family child care providers to participate in the health and safety training pilot program. Most of the agency's child care providers were low income with an average household income 15% below the median household income for the state. There were eight African-American, seven Caucasian, and five Hispanic providers. Seventeen of the providers worked without assistants. Since four of the Hispanic providers spoke very little English, the writer arranged to have an interpreter for the training sessions. Throughout the course of the implementation the writer gave six workshops covering the following topics:

1. Orientation. The writer met with all participants and outlined what the workshops would cover. The meeting provided an opportunity for all providers to become acquainted, and it also allowed the group to set the times and dates for the future

sessions.

2. Self-esteem. The writer covered 10 ways for the providers to improve their self-esteem. There was a discussion following the lecture, and participants related how increased self-esteem could be of value in their child care settings.

3. Safety. The writer gave each participant a drawing of a typical home in which a child care might be housed. The writer had the participants break into groups of two or three and asked each small group to focus on a particular room, e. g., bedroom, bathroom, living room, etc., and brainstorm ways to make that room safe for children. The small groups wrote down their ideas and then presented them to the whole group. A discussion followed, and additional safety ideas were examined.

4. Creating a healthy child-care environment. The writer covered (a) keeping the children's immunization records up to date, (b) lead paint poisoning, (c) policy and procedures for care for sick children, (d) distribution of medicine, and (e) the importance of using universal precautions when caring for children. The providers were interested to know how they could refuse to accept sick children into their family child care homes and how to contact parents about picking up children who had become

sick while at the family child care home. The writer and providers role played these situations.

5. Professionalism. The writer examined with the group, the topic of professionalism and how it related to the providers. The first half of the workshop examined and explained professionalism in the family child care, and the second half was spent in role playing child care situations where professionalism comes into play.

6. Rescue registration. The writer designed and had printed a rescue registration form that family day care providers could fill out and send to their local fire/rescue departments (see Appendix A). The writer and the participants covered the need for rescue registration, and then with the writer's help, all the providers in attendance (14) filled out rescue registration forms.

The writer also arranged for the providers to receive cardio-pulmonary resuscitation/first-aid training through the state's child care training system. The system provided CPR/first-aid training each month.

During the first weeks of workshop training, the writer sent to the state family child care association for inclusion in their monthly newsletter, an article about the health and safety training and the rescue registration form. The writer had previously compiled a 39-item health and safety checklist to use in her in-home technical visits to family child care homes,

checklist to use in her in-home technical visits to family child care homes, and in her article, the writer asked for suggestions as to what the readers felt should be added to the health and safety checklist. After the article appeared, the writer received many enquiries about the training, as well as many suggestions for the checklist. In the fourth month of the implementation, the writer wrote an update about the progress of the training for the state family child care's association's newsletter, and this article appeared also.

During the first month of the practicum, the writer was a featured speaker at a conference sponsored by the state's family child care association. Using her 39-item checklist, the writer presented to over 60 family child care providers tips on how to set up a safe and healthy family child care home. After the presentation the writer asked for feedback, and the participants offered over a dozen additional items for the checklist.

Simultaneously, the writer began to form a rescue registration committee. The committee was comprised of 13 providers, including 2 providers from the writer's health and safety training group, and the writer. During the first meeting, the committee strategized ways to accomplish a statewide rescue registration for all family child care homes. The committee decided to first send out informational letters to fire/rescue departments across the state to explain in detail what the rescue registration process entailed. Over the following months, the rescue registration committee met

at regular intervals to finish designing the rescue registration form and to finalize plans for its distribution. The writer and one member of the rescue registration committee met with the director of the state's child care licensing agency and discussed the implementation process. The director committed the agency to passing out the rescue registration forms to newly licensed family child care providers and also to all existing family child care providers who renewed their licenses.

The writer spoke with the state fire marshal to bring his office up to date on the project and to ask for input. The fire marshal offered several observations and suggestions that the writer brought back to the committee. Additionally, the fire marshal designated one of his staff members to be the contact person for the writer and the committee. The contact person provided the committee with the addresses and phone numbers of all the fire/rescue departments in the state. The local fire chiefs assisted the writer in promoting the rescue registration project at their local fire/rescue houses. The writer and/or committee members made contact with each of the state's fire/rescue departments, and the departments were instrumental in helping to get the word out about the rescue registration project.

When the writer and the committee first designed the rescue registration form, they planned to send only one copy of the rescue registration form to each of the state's 800 family child care providers.

However, it soon became apparent that the providers would have to have two copies of the form; one to send to the local fire/rescue department, and one to keep for their own files. Also, the committee felt that each fire/rescue department should have a supply on hand for providers who requested them. This large increase in the number of forms that needed to be printed meant that the writer no longer had the funds to cover the printing costs. The writer decided to approach local businesses to see if any would agree to pay for the printing. After the writer had unsuccessfully approached several businesses, a regional pharmacy chain agreed to become involved. The chain agreed to print 2000 of the two-part, no-carbon-required (NCR) forms each year, and in return for printing the forms, the chain asked only that its logo appear on each form. The writer and the committee agreed to this request, and the forms were printed.

After the forms were printed and received by the committee, the writer sent a copy of the form and a press release to all the local newspapers as well as to state and national child care agencies. As a result of the publicity, the writer received requests for the rescue registration forms from providers and organizations in her own state, from several other states, and even from England. The state's human services agency (which regulates in-home relative child care homes) also requested 200 copies of the form for registering in-home relative child care providers with local fire/rescue departments. (In-home relative child care providers care for low-

income eligible children who are related to the provider. The state registers these providers.) Finally, the state family child care association included the forms in the monthly newsletter that it sent to all 600 of its members. As a result of their combined efforts, the writer and the committee not only designed and had printed a rescue registration form, but also eventually had the form distributed to over 1800 family child care providers and other interested parties across the state.

A major component of the practicum was the in-home technical health and safety evaluations conducted by the writer and case workers from the private human services agency. One of the case workers proved invaluable as she was able to act as an interpreter for the four providers who spoke only Spanish. At each family child care the writer would discuss each item on the health and safety checklist (see Appendix B) with the provider. The writer noted that the family child care providers accepted the importance of and the need for health and safety concerns in their family child care homes. However, many of the providers had limited experience in and understanding of developmentally appropriate practices for young children in a family child care environment. The providers asked the writer many questions about how best to maintain a daily schedule for mixed-age groups. Among the most commonly asked questions were (a) how much television viewing was appropriate, (b) what was the best way to approach toilet training, (c) should pillows be used in the cribs of young children, (d)

do all children need a nap each day, and (e) when and how often should a pacifier be used? As a result of these and other questions, the writer increased from 39 to 75 the number of items on the health and safety checklist (see Appendix C).

By the conclusion of the practicum, the writer had accomplished her aim of putting in place a model that increased family child care providers' knowledge of how to provide a safe and healthy family child care environment by (a) getting family child care providers to register their family child care homes with their local fire/rescue departments, (b) developing a health and safety checklist, and (c) getting family child care providers involved in the rescue registration committee for an on-going rescue registration process.

CHAPTER V

RESULTS, DISCUSSION, AND RECOMMENDATIONS

Results

In the writer's state, state-licensed family child care providers had limited knowledge of how to provide a safe and healthy environment in their family child care homes. The writer developed a rescue registration form that family child care providers could use to register their family child care homes with their local rescue/fire departments. In order to help family child care providers achieve higher levels of health and safety, the writer first trained 20 family child care providers in health and safety as those issues relate to family child care homes, and then conducted in-home technical assistance visits at each of the family child care homes. Also, the writer set up a committee for the purpose of conducting an on-going statewide rescue registration for all family child care homes.

The writer had three projected outcomes for the implementation:

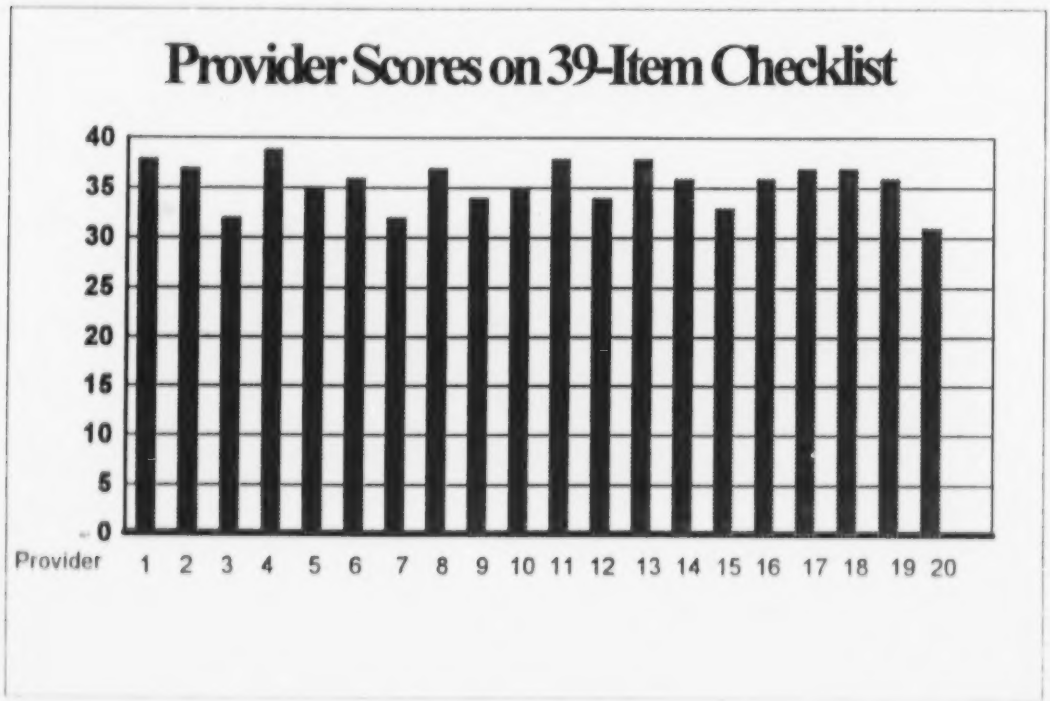
1. Fifteen of the 20 family child care providers would register with their local fire/rescue departments as evidenced by the providers giving a copy of the completed form (see Appendix A) to the writer. By the conclusion of the intervention 14 providers had registered with their local fire/rescue departments and given copies of the registration form to the writer. This

projected outcome was not successful.

2. Fifteen of the 20 family child care providers would improve the health and safety standards in their family child care homes as measured by the providers completing 30 out of 39 criteria on the writer's health and safety checklist (see Appendix C). By the conclusion of the intervention 20 of the 20 family child care providers had completed at least 30 of the 39 criteria on the writer's health and safety checklist (see Table 1, below).

Table 1

Provider Scores on 39-Item Checklist



This projected outcome was 100% successful.

3. Five of the 20 family child care providers would commit to becoming members of a committee to implement a statewide rescue registration project. The providers would sign a consent form stating they were willing to participate, and the writer would use a checklist to list all those who committed to become committee members. Only two of the providers agreed to become committee members. This projected outcome was not successful.

Discussion

The writer was pleased that her first projected outcome of having 15 of 20 providers register their family child care homes with their local fire/rescue departments was nearly achieved when 14 providers had registered by the thirty-second week of the implementation. The reasons the six providers did not register were as follows:

1. Four of the providers who did not register spoke Spanish as their primary language, and the forms were printed only in English. These providers may also have been intimidated by the prospect of having to interact with their local fire/rescue departments.
2. One of the providers moved out of state.
3. One of the providers left the private human service family child

care system.

The writer feels her second projected outcome of having the family child care providers meet 30 of the 39 criteria listed on the writer's checklist (see Appendix B) was more than realized because of the following:

1. The training workshops that the writer conducted.
2. The writer's in-home technical assistance visits.
3. The continued oversight of the providers' family child care homes by the case workers from the private human services agency.

However, while the writer felt that the second projected outcome of the practicum had been successfully reached and the first projected outcome nearly reached, she also realized that because these providers were under the close scrutiny of the private human services agency, such a pattern of success may not be able to be duplicated with providers who are not under such close supervision. Also, while the providers achieved compliance with certain areas of the checklist, such as having a fire extinguisher available, having the correct hot water temperature, and having a posted evacuation plan, the providers did not always meet other criteria, such as not having children walking with bottles and pacifiers, having separate nap and play areas for babies, and not using pillows in young children's cribs. As a result of these observations and feedback she had received from newsletter articles she had written and presentations she had given, the writer revised

and expanded the checklist to include an additional 36 items to bring the total number of checklist items to 75 (see Appendix C).

The writer feels her third projected outcome of having five providers commit to becoming members of a committee to implement statewide rescue registration was unrealistic. All of the participants who had taken part in the training sessions had very busy schedules, and almost all of them worked 50 to 60 hours a week. Therefore, it was difficult for them even to find the time for the health and safety training workshops; participation on the rescue registration committee was asking them to stretch their schedules even further. Also, four of the providers in the implementation spoke only Spanish, and three of them had no transportation. Nevertheless, two providers agreed to become members of the committee, but only attended on a limited basis. In addition to encouraging the participants of the intervention to become members of the rescue registration committee, the writer also advertised for members in the state's family child care newsletter. The writer was highly encouraged when 11 providers responded. The writer was even more encouraged when 13 providers, including the 2 providers from the training sessions, attended the first meeting of the rescue registration committee.

Because of the success of the project and the interest that it generated, the state's family child care association asked that the rescue registration committee become a permanent subcommittee of their

organization. Further, the family child care association membership voted to make the rescue registration process a permanent budget item for the association.

Recommendations

The writer recommends the following to anyone wishing to set up a health and safety training/registration for family child care providers:

1. Schedule convenient training times, dates, and locations in order to encourage providers' attendance.
2. Select a training site that is on a bus line so that all providers can attend.
3. Set up car pools among the providers so that they can all attend the training sessions.
4. Have rescue registration forms printed in several languages.
5. Include a training session on developmentally appropriate practices for young children and how to schedule a child's day in a family child care home.
6. Have the state family child care association include in its annual budget money for the printing and distribution of family child care rescue registration forms.

Dissemination

The writer plans to issue a copy of the practicum to her state and

national child care associations and also the state's human services agency. The writer will also encourage the use of the findings of the practicum at national and state conferences.

The writer received a telephone call from the National Center of Education in Maternal and Child Health (NCEMCH) in Arlington, Virginia, requesting a copy of the writer's concept paper along with a copy of the rescue registration form. The NCEMCH then included these in an E-mailing to child care providers across the country. Also, the writer received many letters and phone calls from local fire/rescue departments thanking her for the project. The departments said that the writer's rescue registration effort had assisted them in planning for emergency situations. They requested that they continue to receive information about the project and many wanted to know how to extend the project to non-licensed child care homes and licensed family child care homes that had not already registered with their local fire/rescue departments. The writer steered them to the rescue registration committee that was now operating under the auspices of the state's family child care association

. The rescue registration form will continue to be shared with anyone who requests a copy. Additionally, the writer plans to submit copies of the form to child care journals, newsletters, and parent/child magazines. The state family child care association will mail 800 copies of the rescue registration form to family child care providers each January, and the state's

child care licensing agency will disseminate the rescue registration forms to all providers renewing their licenses as well as all newly licensed providers.

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APPENDIX A

FAMILY CHILD CARE RESCUE REGISTRATION FORM

FAMILY CHILD CARE RESCUE REGISTRATION FORM

Send top copy to your nearest fire/rescue station. Keep bottom copy for your files.

Date of Registration _____

Provider's Name _____

Street Address _____

City/Town _____ State _____ Zip Code _____

Phone _____

Licensed Family Child Care Home? Yes ____ No ____

License # (If Applicable) _____

Hours of Operation _____

Maximum Number of Children (Including Own Children) in Home at Any Time _____

Age Range of Children in Child Care _____

Employee(s)/Assistant(s) Present: Yes ____ No ____ If Yes, What Are Their Hours? _____

Language Commonly Spoken in Home _____

Describe where exactly in your home you provide Child Care. Include as much information as possible, including the type of home (single, multi-family, etc.), which floors and rooms you use. Describe main entrance to Child Care and any additional entrances, etc.

_____

_____

_____

_____

_____

_____

_____

Other important information, such as special needs children/adults, animals, etc.

_____

_____

_____

_____

_____

Designed and prepared by Mary Ann Shallcross 401-724-3464

Sponsored by

CVS/pharmacy

APPENDIX B

FAMILY CHILD CARE SAFETY AND HEALTH CHECKLIST

FAMILY CHILD CARE SAFETY AND HEALTH CHECKLIST

Date_____

PROVIDER'S NAME_____
STREET ADDRESS_____
CITY/TOWN_____STATE_____ZIP_____
TELEPHONE ( )_____

- ☐ 1. All state DCYF paperwork for each child is completed and individually filed with child's name on folder.
- ☐ 2. Proper provider/child license numbers are met at all times.
- ☐ 3. All insurance current, including liability, accident, car, renter's or home owners', worker's compensation insurance.
- ☐ 4. At all times children are supervised by adults in and out of doors.
- ☐ 5. An evacuation plan is posted in a conspicuous location.
- ☐ 6. Fire drills are practiced monthly and documentation is filed.
- ☐ 7. Bathroom doors do not have locks.
- ☐ 8. Tap water is under 120 degrees F.
- ☐ 9. Food served to children is at proper temperature (140 degrees F).
- ☐ 10. Food is served in child-sized pieces that protect children from choking.
- ☐ 11. Handles on pots and pans are face-in on stove.
- ☐ 12. Dangerous articles are out of the reach of children.
- ☐ 13. Cleaning materials and harmful household products are in a safe, locked area, and out of reach of children.
- ☐ 14. Trash is out of children's reach (preferably in lidded container).

- ☐ 15. There are no toys small enough to fit through a toilet paper tube, e. g., marbles, balloons, etc.
- ☐ 16. There are smoke detectors installed and in working order.
- ☐ 17. There is a boiler heating switch installed and in working order.
- ☐ 18. All electrical outlets are covered and child-proofed.
- ☐ 19. Plastic bags are not used where children are present, including cribs.
- ☐ 20. There is an easily accessible fire extinguisher in working order.
- ☐ 21. The fire extinguisher is type ABC.
- ☐ 22. Emergency numbers are posted by the telephone.
- ☐ 23. CPR certification has been updated yearly (exp. date _____).
- ☐ 24. First aid certification updated yearly (exp. date _____).
- ☐ 25. There are signed permission cards for any non-routine activities.
- ☐ 26. Outdoor play area equipment is designed to be safe.
- ☐ 27. Sandboxes have covers to eliminate use by animals.
- ☐ 28. There are disposable rubber gloves available for use in diapering, cleaning of children, and any bleeding incidents.
- ☐ 29. Children and providers wash hands regularly, and always after play, diapering, toileting, food handling, aiding a sick child, etc.
- ☐ 30. Handwashing sign is present.
- ☐ 31. Towels are labeled for each child, or disposable towels are used.
- ☐ 32. Diaper area is cleaned after each use.

- ☐ 33. Cribs, cots, and mats have at least two feet of separation between them when in use.
- ☐ 34. There are written guidelines for caring for sick children.
- ☐ 35. There is a signed permission sheet for administering medication to children, and the dosages to be given are clearly indicated.
- ☐ 36. The child's name must be on the label of any prescription medication given to that child.
- ☐ 37. Any pets in home have received the necessary vaccinations and documentation is on file and available in home.
- ☐ 38. Home is smoke free and a no smoking sign is posted.
- ☐ 39. Furniture is secure and cannot be pulled or pushed by children.

APPENDIX C

EXPANDED FAMILY CHILD CARE PROVIDER HEALTH AND SAFETY CHECKLIST

FAMILY CHILD CARE SAFETY AND HEALTH CHECKLIST

Date_____

PROVIDER'S NAME_____
STREET ADDRESS_____
CITY/TOWN_____STATE_____ZIP_____
TELEPHONE ( )_____

- ☐ 1. All state DCYF paperwork for each child is completed and individually filed with child's name on folder.
- ☐ 2. Proper provider/child license numbers are met at all times.
- ☐ 3. All insurance current, including liability, accident, car, renter's or home owners', worker's compensation insurance.
- ☐ 4. At all times children are supervised by adults in and out of doors.
- ☐ 5. An evacuation plan is posted in a conspicuous location.
- ☐ 6. Fire drills are practiced monthly and documentation is filed.
- ☐ 7. Bathroom doors do not have locks.
- ☐ 8. Bathroom items such as blow dryers, curling irons, razors, etc., are out of the reach of children.
- ☐ 9. Tap water is under 120 degrees F.
- ☐ 10. Food served to children is at proper temperature (140 degrees F).
- ☐ 11. Food is served in small, cut-up pieces that protect children from choking.
- ☐ 12. Baby bottles are emptied and cleaned after each feeding.
- ☐ 13. Babies are not allowed to walk around with bottles.
- ☐ 14. Handles on pots and pans are face-in on stove.
- ☐ 15 Dangerous articles are out of the reach of children.
- ☐ 16. Cleaning materials and harmful household products are in a safe, locked area, and out of reach of children.
- ☐ 17. Trash is out of children's reach (preferably in lidded container).
- ☐ 18. Proper child-sized equipment is in use in child care areas.
- ☐ 19. Children have ample space to play and play pens are use infrequently.
- ☐ 20. Equipment used by children is in good working condition.
- ☐ 21. Toys are safe for play and cleaned frequently.
- ☐ 22. There are no toys small enough to fit through a toilet paper tube.
- ☐ 23. A daily child care schedule is posted.
- ☐ 24. Television is used minimally.

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- ☐ 25. There are smoke detectors installed and in working order.
- ☐ 26. There is a boiler heating switch installed and in working order.
- ☐ 27. All electrical outlets are covered and child-proofed.
- ☐ 28. Heaters and fans are located a safe distance away from children.
- ☐ 29. Electrical cords are not overloaded or unsafe.
- ☐ 30. Safety gates are placed where needed.
- ☐ 31. Firearms are stored in a proper fashion.
- ☐ 32. There are safety locks where needed.
- ☐ 33. Fireplaces and wood stoves are child-proofed.
- ☐ 34. Plastic bags are not used where children are present, including cribs.
- ☐ 35. There are no poisonous plants in the home.
- ☐ 36. There is an easily accessible fire extinguisher in working order.
- ☐ 37. The fire extinguisher is type ABC.
- ☐ 38. There is at least one easily accessible first-aid kit.
- ☐ 39. Emergency numbers are posted by the telephone.
- ☐ 40. CPR certification has been updated yearly (exp. date _____).
- ☐ 41. First aid certification updated yearly (exp. date _____).
- ☐ 42. There are signed permission cards for any non-routine activities.
- ☐ 43. There are signed permission cards for transporting children.
- ☐ 44. Provider follows state regulations for seating children in vehicles.
- ☐ 45. Outdoor play area equipment is designed to be safe.
- ☐ 46. Sandboxes have covers to eliminate use by animals.
- ☐ 47. If there is a swimming pool, there are posted rules governing proper behavior.
- ☐ 48. Universal precautions are used during contact with bodily fluids.
- ☐ 49. There are disposable rubber gloves available for use in diapering, cleaning of children, and any bleeding incidents.
- ☐ 50. Children and providers wash hands regularly, and always after play, diapering, toileting, food handling, aiding a sick child, etc.
- ☐ 51. Handwashing sign is present.
- ☐ 52. Towels are labeled for each child, or disposable towels are used.
- ☐ 53. Diaper area is cleaned after each use.
- ☐ 54. Bleach/water solution (1/4 cup bleach per gallon of water, or 1 tbsp bleach per quart of

water) is ready and available for use.

- ☐ 55. Home is clean.
- ☐ 56 Children are protected from sun by sunscreens, hats, short durations of time spent in sun, etc.
- ☐ 57. Winter temperatures are taken into consideration for outdoor play.
- ☐ 58. Home is well ventilated, especially nap area.
- ☐ 59. Each child's sleeping and personal items (combs, brushes, etc.) are used exclusively by that child.
- ☐ 60. Cribs, cots, and mats have at least two feet of separation between them when in use.
- ☐ 61. Babies have separate nap and play areas.
- ☐ 62. During nap times, there is a monitor providing a constant visual check.
- ☐ 63. Pillows are not used in any infant cribs.
- ☐ 64. Parent or guardian chooses sleeping position (back, prone, side) of baby.
- ☐ 65. There is a readily available resource on how to handle illness and injury.
- ☐ 66. Children are not allowed to walk with pacifiers.
- ☐ 67. There are written guidelines for caring for sick children.
- ☐ 68. Oral and rectal thermometers are not used.
- ☐ 69. There is a signed permission sheet for administering medication to children, and the dosages to be given are clearly indicated.
- ☐ 70. The child's name must be on the label of any prescription medication given to that child.
- ☐ 71. Out-of-date medication is not administered to children.
- ☐ 72. All injuries that happen to children must be logged, and parents or guardians must sign.
- ☐ 73. Any pets in home have received the necessary vaccinations and documentation is on file and available in home.
- ☐ 74. Home is smoke free and a no smoking sign is posted.
- ☐ 75. A rescue registration has been filed with the local fire/rescue department.

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